Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period October 2004-December 2004

Introduction

This report presents second quarter of fiscal year 2005 (October 2004-December 2004) findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD). The information is based on the most current data available, and where possible is aggregated at both statewide and district or complex levels. Tracking and analysis of this data helps CAMHD and stakeholders determine how well and how efficiently CAMHD is delivering care and impacting child outcomes.

CAMHD tracks data in four major areas: Population, Service, Cost, and Performance Measures. Population information describes the demographic characteristics of the children and youth served by CAMHD. Service information is compiled regarding the type and amount of direct care services provided. Cost information is gathered about the financial aspects of services. Performance Measures, including Outcome data, are tracked to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extents to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected

CAMHD continues to report on measures of interest to the Federal Courts regarding the sustainability of improvements that have been made in the children's mental health service system in Hawaii. These measures are:

1) CAMHD outcome and results components will be implemented (Benchmark 22),
2) CAMHD will have developed appropriate CSPs for all children whose care is coordinated by CAMHD (Benchmark 26),
3) Service gap analysis (unserved youth report) will document that no child will wait longer than 30 days for a specified service or appropriate alternative…CAMHD will document in the quality improvement reviews that appropriate referrals are being made (Benchmarks 33 and 54-deemed completed),
4) Personnel and Vacancy Reporting,
5) Benchmarks that describe complex-based service testing, and
6) Complaints (no Benchmark attached, reporting requested by the Felix Monitoring Project).

Pursuant to the Stipulation for Step-down Plan and Termination of the Revised Consent Decree, this report also presents data by Family Guidance Center for numbers of children and youth served by CAMHD, percentage of care coordinator positions filled, and percentage of youth served who have a Coordinated Service Plan.

CAMHD Performance Management System

Use of data to improve services and service delivery

The CAMHD Performance Management system provides CAMHD with mechanisms to examine performance and use information to make decisions about any needed adjustments to program implementation. Performance data in CAMHD are tracked across all aspects of service delivery and care. Data collection and analysis are conducted systematically and spans all areas of performance. This information is critical to determine how well the system is performing for youth, and how well youth are progressing. It is sensitive enough to determine if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring. Services are monitored through tracking of trends and patterns found in utilization and satisfaction data, and examinations of practice and quality of services.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data presented here are for youth registered in the CAMHD Family Guidance Centers during the second quarter of fiscal year 2005 (October 2004-December 2004). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,793 youth across the State, a decrease of 32 from the previous reporting quarter (July 2004-September 2004), or a 2% decrease in the total population. This is the second quarter since the beginning of fiscal year 2004 that there has been a decrease in the population. Registered population increases were experienced in almost all Family Guidance Centers with the exception of Honolulu FGC and Family Court Liaison Branch. Since the same period last year (October 2003-December 2003), CAMHD has experienced a 7% overall increase in its registered population.

The numbers of youth registered at each of the Family Guidance Centers during the first quarter are displayed in Table 1. The numbers for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. The largest population continues to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 24% of the total CAMHD population during the quarter. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, had the smallest population and served 3% of the registered CAMHD population.

Table 1. Population of Youth Registered by Family Guidance Center, FY 2005, Quarter 2 (October 2004-September 2004)

COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
157	217	170	144	147	430	483	45

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 968 had services that were authorized within the quarter.

Of the registered population (1,793), 124 youth (6.9%) were newly registered (had not previously received services) in the second quarter of fiscal year 2005. This represents an increase of 11 new admissions from the previous quarter (July 2004-September 2004). One hundred eight (108) youth (6.0%) were reregistered who had previously received services from CAMHD, a decrease from last quarter's readmissions of 112 youth. CAMHD discharged a total of 181 youth during the quarter, or 10.1% of the registered population. This is a decrease from last quarter's discharge of 200 youth (11.4% of the registered population).

Of the 985 youth who had services authorized in the quarter, 56 were new admissions (5.7%), 49 repeat admissions (5.0%) and 47 discharges (4.8%). Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth, age range and percentage of males versus females continues to be stable among the CAMHD population. The average age of registered youth in the reporting quarter was 14.3 years with a range from 3 to 20 years. The majority of youth, as seen in Table 2 were male (67%).

Gender	N	% of Available
Females	593	33%
Males	1,200	67%

Table 2. Gender of CAMHD Youth

The races of youth registered in the reporting quarter are displayed in Table 3. Beginning with this quarter, data are reported as race versus the previous reporting of ethnicity. CAMHD has begun collecting race and ethnicity data with categories that are in closer alignment with U.S. Census reporting.

Multiracial youth represented the largest racial group (64.3%), followed by White youth (17.4%), and then Native Hawaiian or Pacific Islanders (10.0%). Please note that race data was not available (no data entered) for 61.6% of youth registered, largely because the system has not yet fully converted to the new methodology of capturing race and ethnicity data.

Table 3. Race of Youth (Unduplicated)

Ethnicity	N	% of Available
American Indian or Alaska Native	0	0.0%
Asian	41	6.0%
Black or African-American	11	1.6%
Native Hawaiian or Pacific Islander	69	10.0%
White	120	17.4%
Other Race	5	0.7%
Multiracial	443	64.3%
Based on Observation	52	7.5%
Not Available (% Total)	1,104	61.6%

Subpopulations of youth who receive services through CAMHD are concurrently involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 4). In the quarter, 10.9% were involved with DHS, 25.5% had a Family Court hearing during the quarter, and 7.3% were incarcerated at HYCF or detained at the Detention Home. Youth who were eligible for services through the Serious Emotional and Behavioral Disturbance (SEBD) process numbered 567 and were 31.6% of the registered population. This was an increase of 109 youth in the SEBD category over the previous quarter (July 2004-September 2004). In order to reduce stigma, and provide a family-friendly orientation to services, CAMHD has renamed its SEBD services to "Supporting Emotional and Behavioral Development." Services to youth through the SEBD process occurs by virtue of the Memorandum of Agreement (MOA) with the Med-QUEST Division, which allows any QUEST or Medicaid fee-for services eligible youth who meet criteria for this designation to receive services through

Table 4. Agency Involvement

Agency Involvement	N	%
DHS	195	10.9%
Court	458	25.5%
Incarcerated/Detained	131	7.3%
SEBD	567	31.6%
Quest	638	35.6%

CAMHD. The process for referring youth for SEBD services has been widely disseminated to encourage easier access to needed behavioral health services. Information on the SEBD referral process can be found at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/service-access/index.html. QUEST-eligible youth who received services in the quarter were 35.6% of the population. The total number of QUEST enrolled youth was down from last quarter, when 656 youth with QUEST insurance were registered with CAMHD. Some QUEST-eligible youth may not have been screened through the SEBD process, and are eligible because of their educational or court-ordered status.

Table 5. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Attentional	740	45.1%
Disruptive Behavior	738	44.9%
Mood	596	36.3%
Miscellaneous	402	24.5%
Anxiety	303	18.5%
Substance-Related	256	15.6%
Adjustment	199	12.1%
Mental Retardation	33	2.0%
Pervasive Developmental	28	1.7%
Multiple Diagnoses	1,200	73.1%
Ave. Number of Diagnoses	1.9	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 5). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top three diagnoses of youth with registered services in the quarter continued to be Attentional disorders (45.1%), Disruptive Behavior disorders (44.9%), and Mood disorders (36.3%). In previous quarters, the diagnostic breakdown was fairly consistent. This quarter, there was a 4.1% increase in youth with Attentional disorders. Miscellaneous diagnoses accounted for 24.5% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter, 73.1% of registered youth had more than one diagnosis, with an average of 1.9 diagnoses per youth. This is a slight increase from the previous quarter (July 2004-September 2004) when 68.1% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (78.9%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-occurring diagnoses. The co-occurring diagnoses category includes any DSM-identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 15.6% of the registered population, an increase of .6% over the previous quarter. Please note that these data were incorrectly reported last quarter. Correct data should reflect that 14.8% of youth had a substance-related diagnosis in the first quarter, rather than the 17.5% that was mistakenly reported.

This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment. Any youth registered with CAMHD that presents in a treatment program with a substance related issue receives treatment services as indicated.

Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (October 2004-December 2004). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served were authorized to receive services provided in the home and/or community, which consist of Intensive In-Home services (48.0%) and Multisystemic Therapy (MST) (14.2%). The percentages of youth receiving services in these in-home categories increased slightly for Intensive In-Home and decreased slightly for MST over the last quarter's percentages. In the last quarter, (July 2004-September 2004), 46.3% of youth received Intensive In-Home services and 14.7% of youth received MST.

Table 6. Service Authorization Summary (October 1, 2004-December 31, 2004).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	7	7	0.4%	0.7%
Hospital Residential	23	35	2.0%	3.6%
Community High Risk	9	10	0.6%	1.0%
Community Residential	126	163	9.1%	16.5%
Therapeutic Group Home	71	89	5.0%	9.0%
Therapeutic Family Home	123	141	7.9%	14.3%
Respite Home	1	2	0.1%	0.2%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	102	140	7.8%	14.2%
Intensive In-Home	392	473	26.4%	48.0%
Flex	100	168	9.4%	17.1%
Respite	29	31	1.7%	3.1%
Less Intensive	47	106	5.9%	10.8%
Crisis Stabilization	5	12	0.7%	1.2%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

The largest group of youth in an out-of-home setting received services in a Community-Based Residential program (16.5%). The percentage of youth receiving these services was slightly down from the previous quarter's (July 2004-September 2004) authorizations for 17.1% of the registered population. Youth receiving treatment while in Therapeutic Family Homes accounted for 14.3% of those served (slightly up from the previous quarter's 14.2%), and Therapeutic Group Homes 9.0% (down from 10.6% in the previous quarter).

In the reporting period, Flex services were provided for 17.1% of youth served. Flex services are a broad category that range from mental health services not provided through a regular purchase of service contract, to travel for youth in off-island residential programs, to interpretive services. They may also include purchase of assessments.

Flex services have historically been a key component of the Hawaii system of care, and has allowed for flexible, and often low cost, supports to youth and families. Flexible services are designed primarily to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services. Research has shown that flexible funds are associated with increased capacity of caregivers to provide care and "do their job."

Respite Home services continued to have relatively low utilization with no youth accessing this service, as opposed to 3.0% of the served population receiving an authorization for this service last quarter.

Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the first quarter of fiscal year 2005 (July 2004-September 2004). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 7. Total cost increases include rate increases that were implemented for most providers in the quarter. Out-of-Home residential treatment services in Hawaii, including Hospital-Based Residential treatment, accounted for 82.3% of service expenditures. This compares to out-of home residential treatment services accounting for 84.6% of the total costs in the fourth quarter of FY 2004, or a 2.3% decrease in percentage of total expenditures. Youth in Out-of-State treatment settings accounted for only 1.6% of total expenditures, which is .2% under last quarter's proportion of cost.

Table 7. Cost of Services (July 2004-September 2004)

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	156,040	26,007	156,040	26,007	1.6%
Hospital Residential[c]	-	-	-	-	-
Community High Risk	310,219	34,469	309,821	34,425	3.1%
Community Residential	4,690,019	26,800	4,274,137	24,424	43.3%
Therapeutic Group Home	2,270,377	21,831	1,853,517	17,822	18.8%
Therapeutic Family Home	2,082,116	15,198	1,684,983	12,299	17.1%
Respite Home	0	-	0	-	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	743,170	5,056	470,823	3,203	4.8%
Intensive In-Home	1,604,900	4,053	858,593	2,168	8.7%
Flex	3,704,443	21,413	168,019	971	1.7%
Respite	101,283	2,813	34,884	969	0.4%
Less Intensive	149,282	16,587	17,487	1,943	0.2%
Crisis Stabilization	101,896	6,793	51,235	3,416	0.5%

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US$). [b] Cost per LOC represents unduplicated cost (US$) for services at the specified level of care. [c] Due to a billing error no accepted records were available for Hospital Residential services during FY 2005 Q1.

The cost of Community-Based Residential Services remained the same as the previous reporting quarter. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth ($34,425 per youth), which has been consistent over time. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($12,299 per youth). Please note that due to a billing error no accepted records were available for Hospital Residential services during FY 2005 Q1. This issue is working toward resolution and will be addressed in future reporting.

In-Home (Intensive In-Home and MST) and Less Intensive services accounted for 13.7% of the unduplicated cost of services, which is higher than the last reporting quarter (April 2004-June 2004) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $4,053 per youth ($2,168 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per any youth in a residential program.

Youth who received Flex services during the quarter had a cost of $21,413 per youth. These youth most commonly receive other treatment services in addition to those flexibly funded. The total cost for the Flex service alone was $971 per month. The average cost per youth for a child receiving Flex at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for flex services suggest that youth in out-of home placements account for a high percentage of youth receiving flex services.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and Family Guidance Centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

Although the Memorandum of Agreement (MOA) between CAMHD and DDD ended in June 2004, the provision of services, supports and coordination for youth with mental retardation and developmental disabilities continued for the target population.

Respite Services

For October, November, December, DDD met respite needs of the target population through the DDD service system. DOH case managers continued with assisting families to access other service options such as DDD Respite (via open enrollment), Home and Community-Based Service—DD/MR (HCBS-DD/MR) waiver program, and other DDD funded supports. The table below shows updated utilization of various DDD services that families accessed to meet their needs.

Table 8. Other Service Options Utilized by CAMHD Respite Recipients

DDD Service	# of Users
*HCBS - DD/MR Waiver	51
**POS - Partnerships in Community Living (PICL)	5
***DDD Respite	36
****Family Support Services Program (FSSP)	11

* Waiver admission as of 12/31/04
** PICL referrals for period of 10/1/04 – 12/31/04
* **DDD Respite (CAMHD recipients who applied in open enrollment of June 2004)
****FSSP enrolled 10/1/04-12/31/04

Table 9. Expenditures to Date for CAMHD Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$148,303.93	44%	$2,031.56
Hawaii	34	26%	$89,714.00	27%	$2,638.65
Kauai	11	8%	$61,644.50	18%	$5,604.05
Maui	14	11%	$37,358.00	11%	$2,668.43
Total Youth	132	Total Dollars Expended (July 2002-December 2004)			$337,020.43

While families accessed DDD service options, there were no respite expenditures for the period October, November, December. The total dollars expended for the target population since July 2002 is $337,020.43.

Residential Services

As reported last quarter, the Individual Community Residential Support (ICRS) contract provides for special treatment facility services for three individuals. Two out of three individuals in the special treatment facility are now adults and continue to successfully transition to DDD's licensed adult foster homes. It is expected that both of these adults will exit the special treatment facility and fully transition into the licensed homes by the end of January 2005. The remaining youth residing in the special treatment facility is in need of a licensed setting for children.

All but one individual of the thirteen youth in the original target population receiving ICRS services have been admitted to the HCBS DD/MR waiver program. This

individual continues to receive psychiatric treatment and hospital-based residential services; DDD continues to seek residential or community-based supports for this youth.

Performance Measures

CAMHD uses performance measures to demonstrate sustainability and adequacy of services, results, infrastructure, and key practice initiatives. They measure the ability to maintain gains made since the inception of the Felix Consent Decree, and achieve CAMHD practice standards. CAMHD has set performance goals for each measure. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

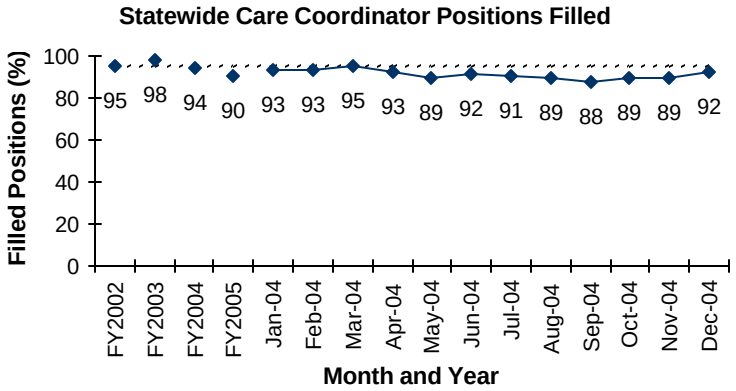
Performance measures linked to previous Court Benchmarks are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ *95% of mental health care coordinator positions are filled**

Over the reporting period, CAMHD had an average of 90% of care coordinator positions statewide filled, which did not meet the performance goal. This performance is slightly above last quarter's average of 89% of positions filled. This quarter's data reflects the fifth consecutive quarter the performance goal was not met since this indicator began to be reported at the start of FY 2002. As discussed last quarter, a major impact on performance for this indicator is the length of time it now takes to fill care coordinator positions.



The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

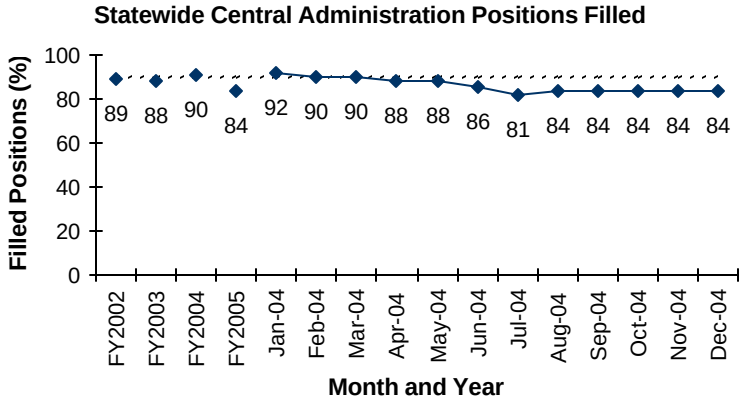
COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
88%	87%	80%	92%	100%	93%	90%

Vacancies in Central Oahu, Leeward Oahu, Maui, Windward Oahu, and the Big Island impacted the Statewide average over the last quarter. Each of these FGCs experienced an average of between one and two vacancies. The Leeward and Windward vacancies have been filled, and recruitment is underway for vacancies in the remaining Centers.

Goal:

⇨ *90% of central administration positions are filled**

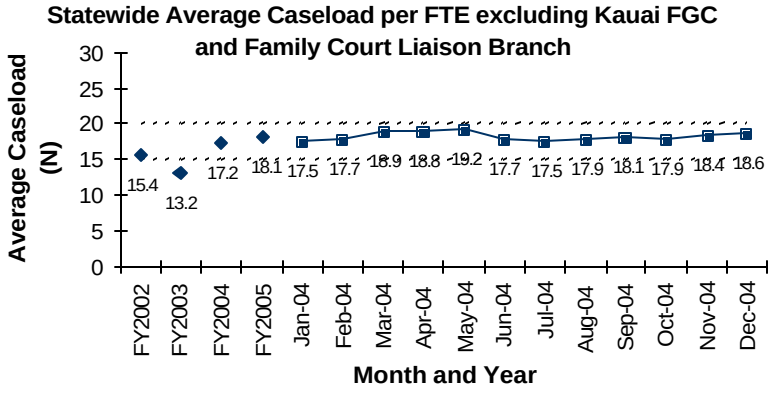
The performance target was not met, as an average of 84% of central administration positions were filled over the quarter, which is below the goal for the third consecutive quarter, but slightly above last quarter's performance (83%). Central Administration positions provide support for the infrastructure and quality management functions necessary to manage the statewide service system. Vacancies across the central administration's offices continue to impact this measure. Three positions in the Performance Management section have recently been filled, and a fourth has been used to fund a contracted monitoring psychologist.



Goal:

⇨ *Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.*

The average caseload for the second quarter was within the target range at 18.3 youth per full time care coordinator equivalent (FTE), which meets the performance goal for the measure. Each of the three months in the quarter met the performance expectation. CAMHD expects that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. Average caseloads have been in the targeted range consistently since the beginning of fiscal year 2004.



Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
2nd Quarter Average	19	21	20	16	15	19

The average caseloads performance target was met for all of the FGCs, except Leeward Oahu FGC where the caseload was one above the expected range. The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center. Other than the Windward Oahu and Honolulu FGCs, all Family Guidance Centers are approaching the upper or slightly past the limit of twenty cases per care coordinator.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ Sustain within quarterly budget allocation.

CAMHD did not meet the goal for sustaining within its budget. The reporting quarter for this performance measure is July-September 2004, which allowed for closing of the contracted agency billing cycle. The total variance from the budget for the reporting quarter was over projection by $4,000.. Projections include service dollars that have been or will be encumbered and/or expended in the remainder of the fiscal year. Sufficient funds were encumbered for all expected service costs.

Expenditures were below budget for services and Central Office expenditures ($2,000 and $15,000 below respectively). Historically, services have accounted for the largest variance, and these expenditures have invariably been below what was budgeted. The Family Guidance Centers accounted for the bulk of the variance above what was budgeted (expenditures were $20,000 over budget).

Variance from Budget (in $1,000's)

	FY 2002 Average	FY 2003 Average	FY 2004 Average	FY2005 Average	2004.1	2004.2	2004.3	2004.4	2005.1
Branch Total	$164	-$150	$20	$20	$134	$62	-$54	-$60	$20
Services Total	$798	-$4,175	-$1,849	-$2	$59	-$3,963	-$3,389	-$101	-$2
Central Office Total	-$189	-$388	-$314	-$15	-$226	-$298	-$344	-$388	-$15
Grand Total	$773	-$4,713	-$2,142	$4	-$33	-$4,200	-$3,787	-$549	$4

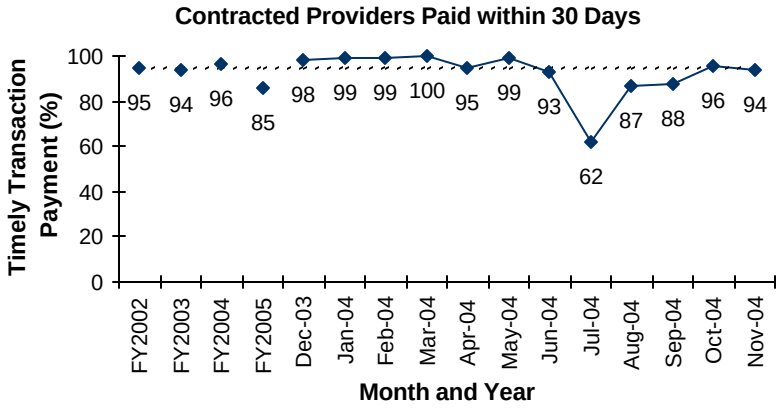
CAMHD will maintain timely payment to provider agencies

Goal:

⇨ *95% of contracted providers are paid within 30 days*

Performance for this measure was just below target as an average of 93% of contractors was paid within the 30-day window over the quarter. This is an improvement of last quarter's average of 81% of contracted providers paid within 30 days. As discussed in last quarter's report, timely payment in the previous quarter (reported for this measure as June-August 2004) was impacted by a Department of Accounting and General Services' (DAGS) interpretation of State regulations regarding electronic billing, which has been since rectified. As anticipated, performance rebounded from the short-term effects of the DAGS action.

As standard for reporting, the quarter's data is available for the first two months of the quarter (October and November 2004), as the last month of the quarter's (December 2004) payments are in mid-cycle as of this report. September 2004 data is reported in the quarter's average.

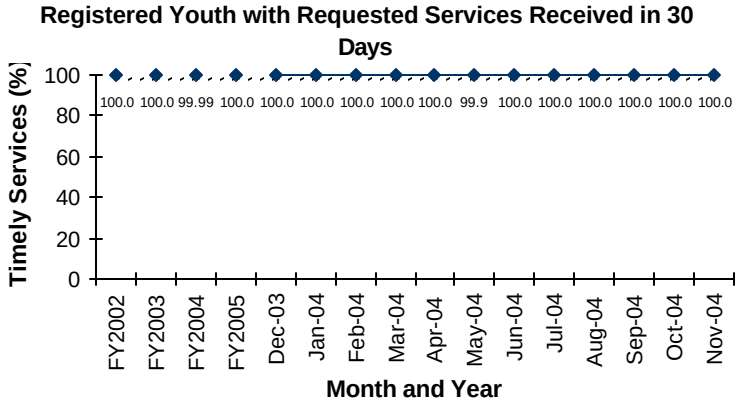


CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ 98% of youth receive services within thirty days of request*

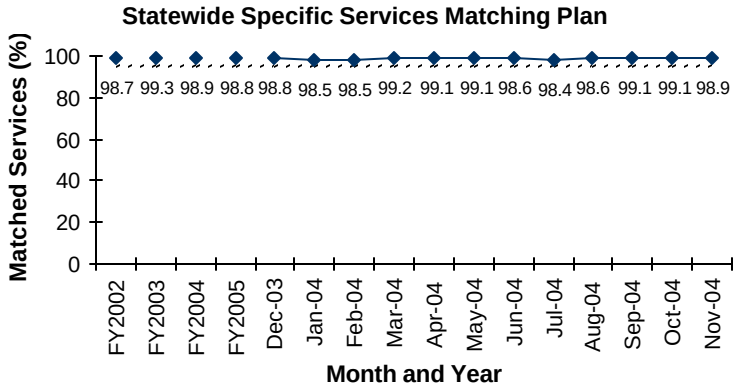
The goal was met for the quarter with 100% of youth provided timely access to services. Data are for the first and second month of the reporting quarter (October and November 2004) as third month data are not available at the time of publication. September 2004 data are included in the average for the quarter.



Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan*

CAMHD continued to demonstrate strong performance on this measure. Over the quarter, 99% of youth received the specific services identified by their team plan. These youth received services within 30 days, but they were not the exact service selected by their service teams. Data are for the first and second month of the reporting quarter (October and November 2004) as third month data are not available at the time of publication. September 2004 data are included in the average for the quarter. This measure includes SEBD youth who do not have an educational plan.



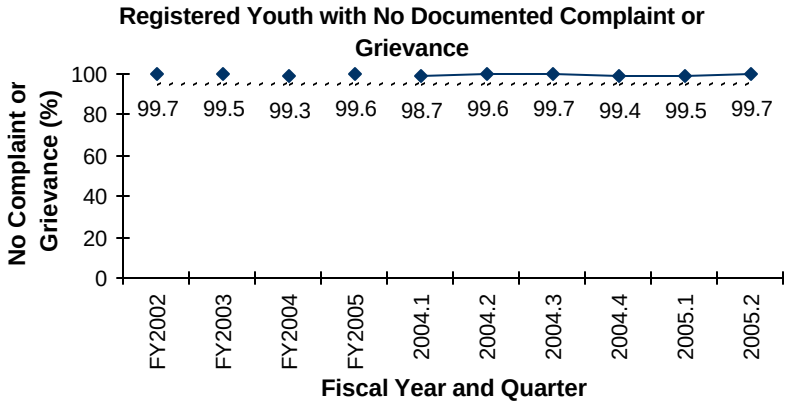
In the quarter, service mismatches occurred in seventeen complexes versus twenty in the previous quarter. Campbell Complex was the outlier at four youth receiving mismatched services. Hilo continued to have mismatches for three youth. Pahoa also had three mismatches. The remaining complexes experiencing mismatches had two or less. Pearl City Complex, which had experienced four mismatches last quarter, had two in the current quarter.

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ 95% of youth served have no documented complaint received*

99.7% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goalhas been sustained since it was established in June 2001.

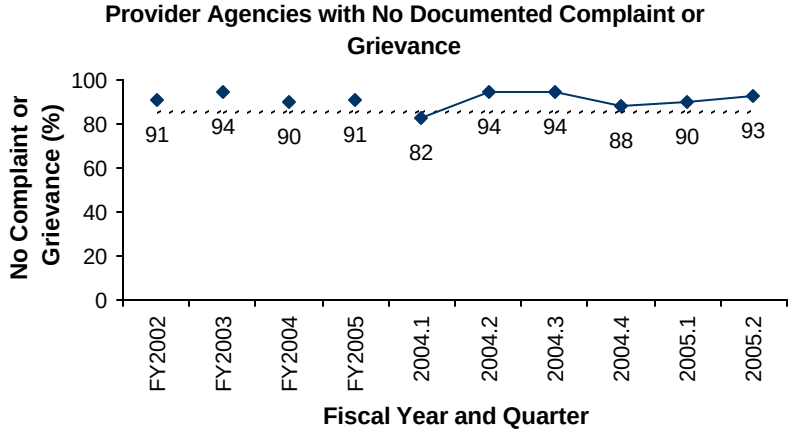


In the quarter, there were complaints received from 5 youth (or someone complaining on their behalf) representing five complexes statewide as compared to 9 youth with documented complaints representing 8 complexes last quarter. There was one complaint for each of the following complexes: Waianae, Kaimuki, Maui High, Molokai, and Laupahoehoe. There were no noticeable trends in the data.

Goal:

⇨ 85% of provider agencies have no documented complaint received

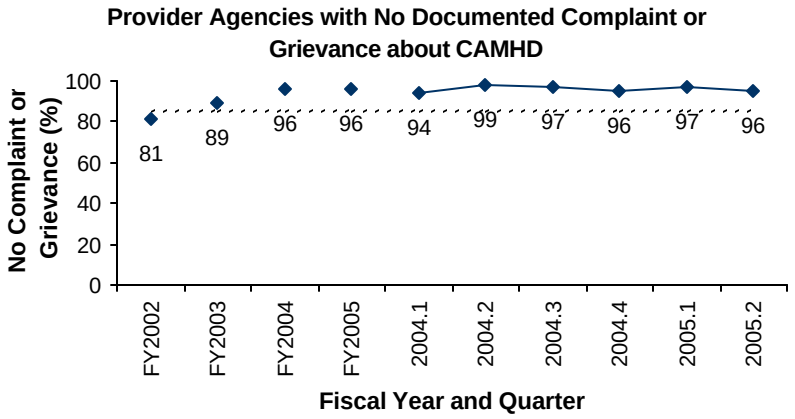
93% of provider agencies had no documented complaint about their services, which met the performance goal. The performance target for this measure has been consistently met since the second quarter of fiscal year 2004.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance*

In the quarter, 96% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure has consistently met the performance goal since the beginning of FY2003.

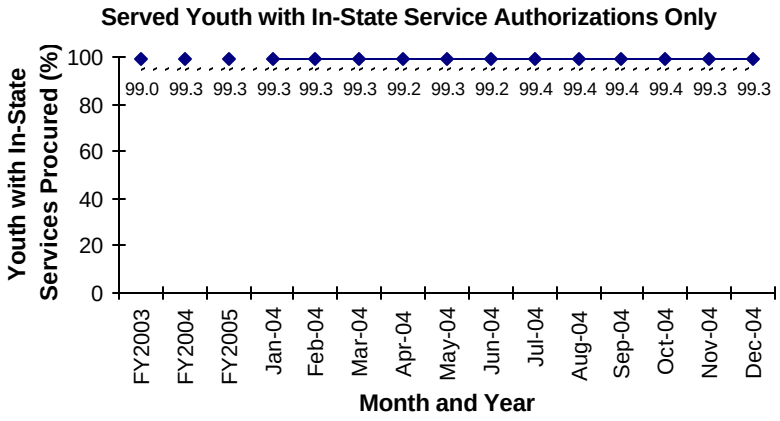


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii*

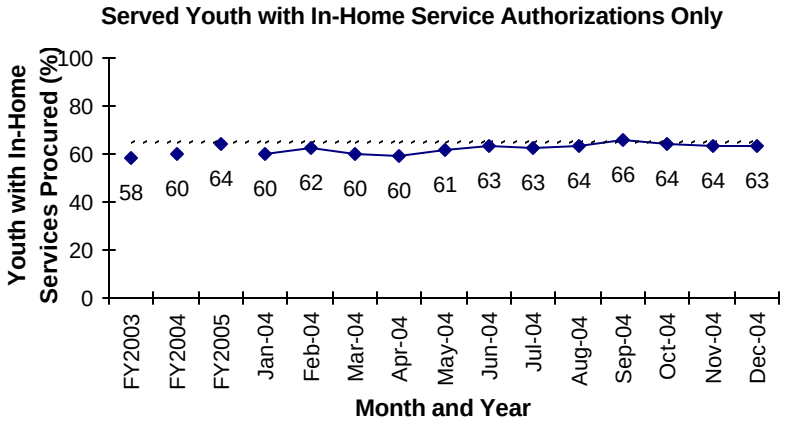
In the quarter, an average of 99.3% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Seven youth received services in out-of state treatment settings in the quarter. These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter.



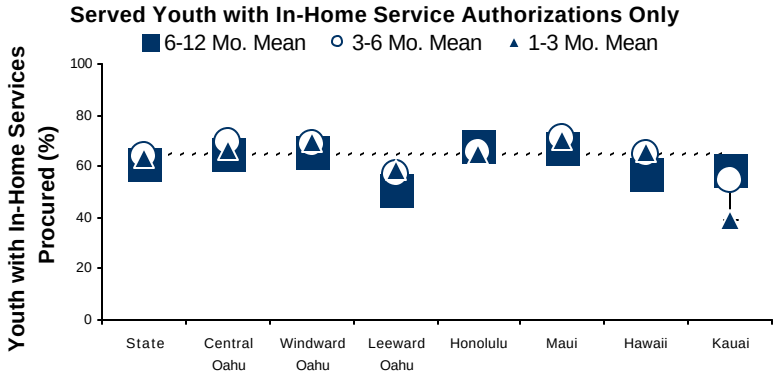
Goal:

⇨ 65% of youth are able to receive treatment while living in their home

The quarter's data showed that an average of 64% of youth were served in their home communities throughout the quarter, which was 1% below the performance goal. The data reflect a slight decrease over last quarter's performance.



There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below. The goal was met for Central Oahu FGC (66.5% served in their homes), Windward Oahu (69.2% served in-home), Honolulu FGC (65.1% served in-home) and Maui FGC (70.4% served in-home) and the Hawaii FGC (66% served in-home). Kauai experienced a substantial decline in performance. The Kauai provider agency for intensive in-home services had a therapist vacancy during the quarter, impacting this measure, which has since been filled. Performance is expected to rebound next quarter with the filling of this vacancy.



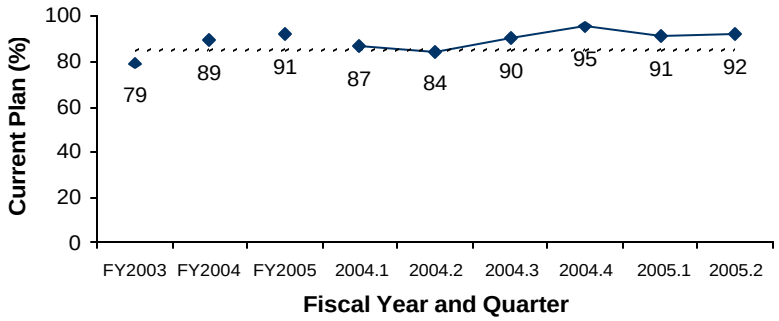
CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

⇨ 85% of youth have a current Coordinated Service Plan (CSP)*

CAMHD's performance in this measure met the performance goal for the reporting quarter with 92% of youth across the state having a current CSP, which was 1% above last quarter's performance. All of the Family Guidance Centers met the performance goal in the reporting period.

Average Coordinated Service Plan Timeliness



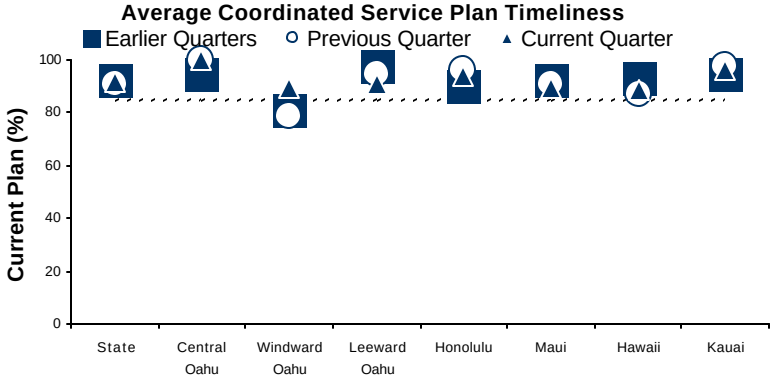
Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

Average CSP Timeliness by Family Guidance Center

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KFGC
100	91	89	89	94	89	96

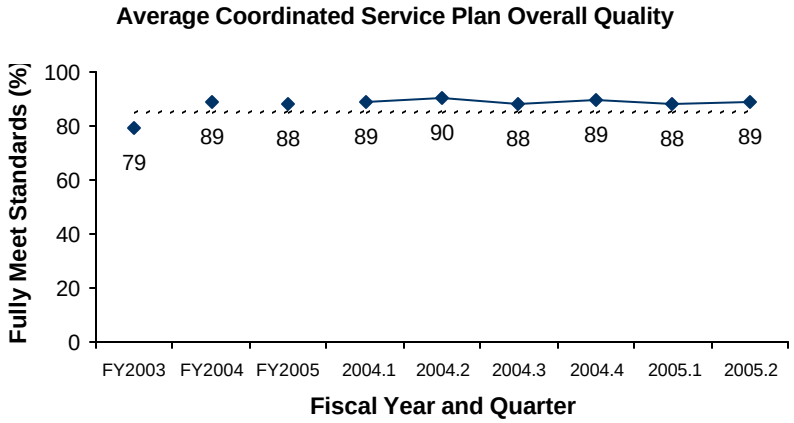
Trend data for each FGC are displayed below. Timeliness improvements were seen in Windward and Hawaii FGCs.



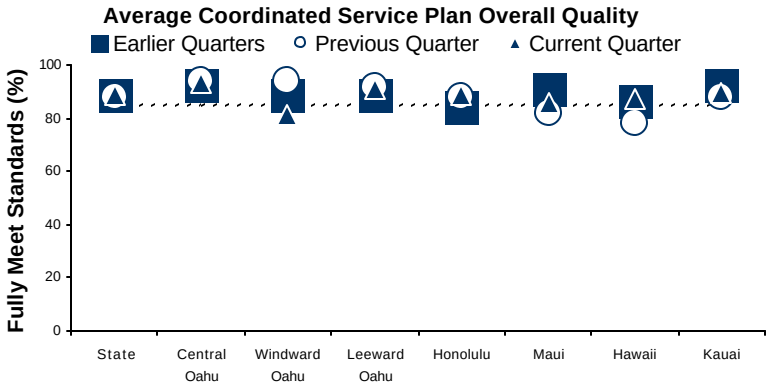
Goal:

⇨ 85% of Coordinated Service Plan review indicators meet quality standards*

The goal for this measure was met in the reporting quarter with 89% of CSPs sampled meeting overall standards for quality statewide. Quarterly reviews of CSPs against standards for effective plans are a part of quality monitoring within each FGC. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, a clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and other key measures. The statewide data for quality of CSPs are displayed below.



As seen in the next chart, the goal was met or exceeded by all FGCs with the exception of Windward FGC, which declined in performance. The Windward FGC will develop specific strategies in their Quality Assurance Committee to address this dip in performance. Maui, Kauai, and Hawaii FGCs showed improvement in the quality of their coordinated service plans.



Mental Health Services will be provided by an array of quality provider agencies

Goal:

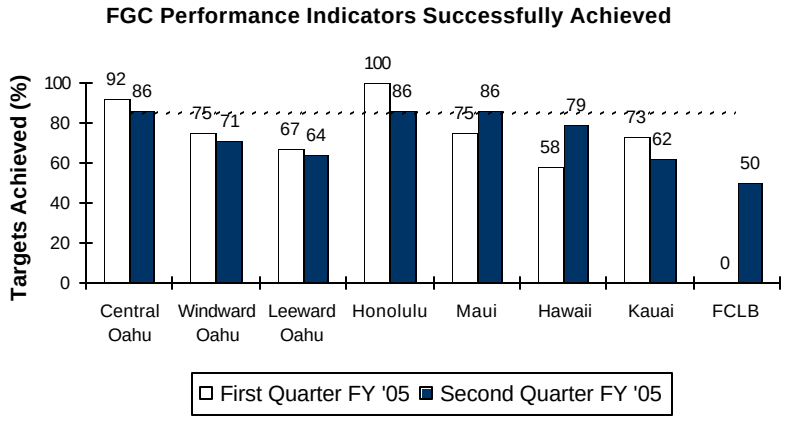
⇨ 85% of performance indicators are met for each Family Guidance Center

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, expenditures within budget, grievances, access to services (service gaps/mismatches, least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

The goal of meeting at least 85% of the performance indicators was met by Central Oahu, Honolulu, and Maui FGCs. On average across all FGCs, 73% of all goals were met in the quarter, compared to 67.5% in the last quarter, and 71% in the previous quarter. Windward, Leeward, Hawaii, and Kauai FGCS, and the FCLB did not meet performance goals.

The Family Guidance Centers generally did well in indicators of caseloads within the designated range, timely access to services, documented complaints from consumers, serving youth in the State, and youth showing improvements as measured by the CAFAS or ASEBA. In the quarter, the cluster of indicators related to child status and filling of care coordinator positions were the areas most of the FGCs struggled with meeting.

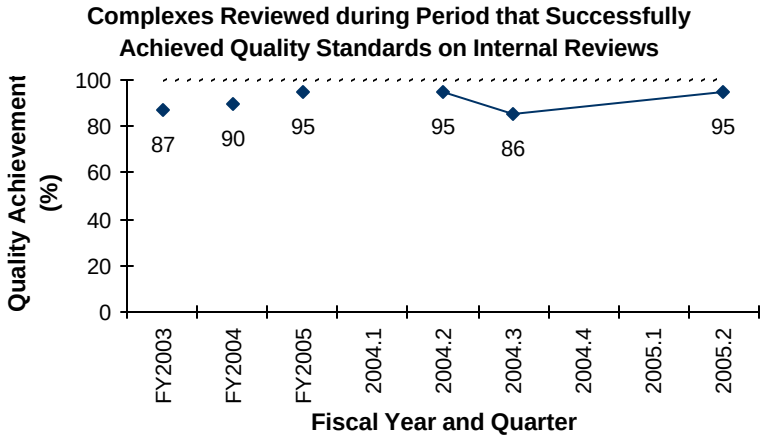
Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. The FGC management team tracks the implementation of each improvement strategy.



Goal:

⇨ 100% of complexes will maintain acceptable scoring on internal reviews.*

Complex internal reviews for the school year started in the second quarter. Of the nineteen complexes reviewed, 95% met the performance goal. One complex, Kalaheo, did not meet the goal. Acceptable scoring continues to be defined as achieving acceptable system performance for 85% of cases reviewed. The performance target is for 100% of complexes to meet the goal for acceptable system performance.

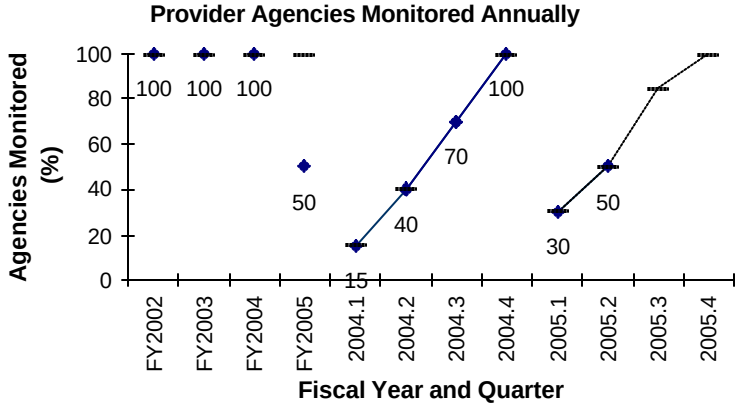


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 100% of provider agencies are monitored annually

The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. Thus far this year, 50% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Four agencies, representing thirteen contracts and ten levels of care were monitored in the second quarter. Please note that the percentage of agencies reviewed in the quarter was adjusted by one agency due to a rescheduling of their annual monitoring review.

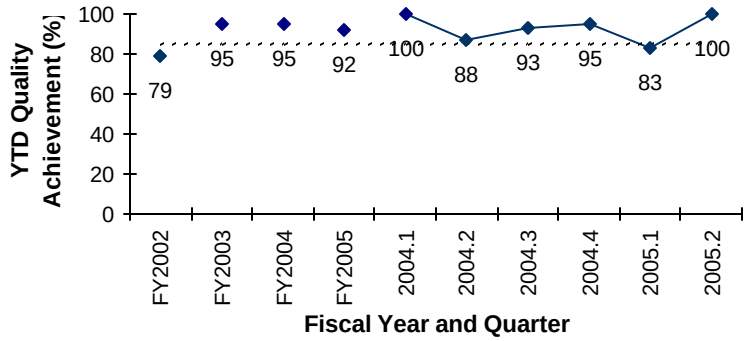


Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, 100% of the provider agencies reviewed in the quarter were determined to be performing at an acceptable level, which met the performance goal. Provider agencies are reviewed across multiple dimensions of quality and effective practices. In the future, it is the intent to modify this measure to report performance as percentage of all contracted agencies currently performing at an acceptable level, which will reflect performance status of all agencies. Currently data for this measure are reported for agencies that underwent the annual performance review in the quarter, and does not reflect the comprehensive and current performance status of all agencies

Provider Agencies Performing at an Acceptable Level



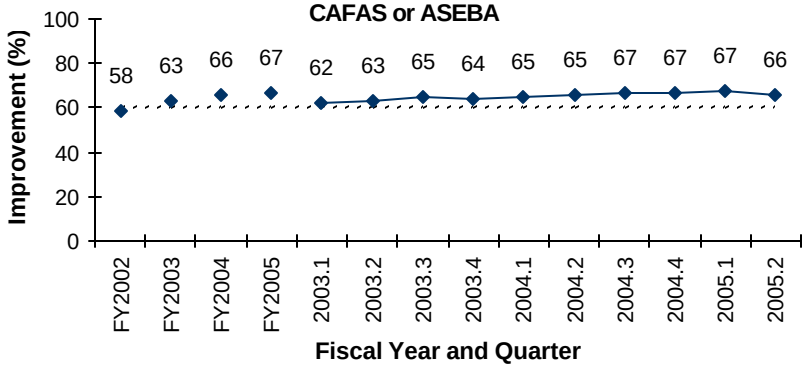
CAMHD will demonstrate improvements in child status

Goal:

⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to submit the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.

Registered Youth with Available Measures Improving on CAFAS or ASEBA

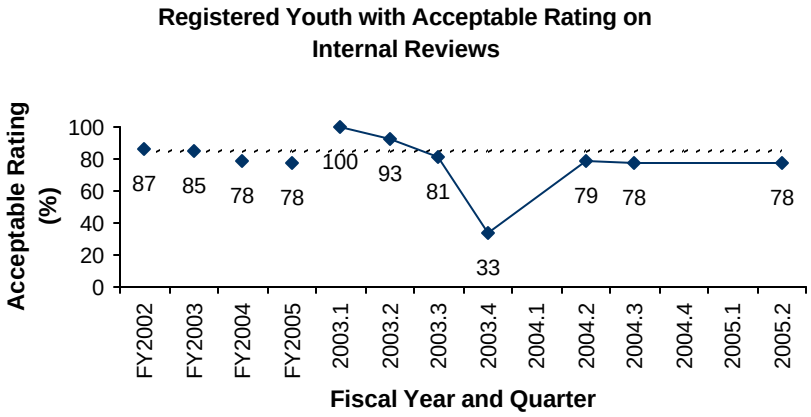


In the reporting quarter, for youth with data for these measures, 66% were showing improvements since entering the CAMHD system, which meets the performance goal. There has been a fairly stable trend in functional improvements for youth served by CAMHD over the past two years. Child functioning as measured by these scales has improved by 8% since the end of FY 2002. This is the first quarter since data have been tracked for this measure in which a slight decline was seen, suggesting that the trend may be leveling off.

Goal:

⇨ 85% of those with case-based reviews show acceptable child status

Of youth receiving care coordination and services through CAMHD, 78% were found to be doing well in measures of child well-being Each child with unacceptable child status ratings are referred to their FGC clinical team for review of factors impacting well-being.



Families will be engaged as partners in the planning process

Goal:

⇨ 85% of families surveyed report satisfaction with CAMHD services

CAMHD now administers the ECHO™ satisfaction survey on an annual basis. The survey builds on widely used instruments for behavioral health care quality assessment, and was designed with the unique needs of populations similar to that served by CAMHD. The next survey will be administered in Spring 2005 and results will be reported in the August 2005 report.

An advantage of using the ECHO™ survey is that it allows for comparison of CAMHD results with other mental health delivery systems. Each fall, data from all the behavioral health plans across the country that use the ECHO™ are released. CAMHD is similar to the other managed care organizations in the ECHO™ national comparison sample in that most of the organizations in the sample focused on behavioral health management. Differences that were seen in several of the comparison organizations include their being integrated medical systems, offering less intensive services and were generally not entirely child focused.

The table below shows the comparison of measures between the National and CAMHD results for the 2004 ECHO™ Survey administration. For the measures of Informed about Treatment Options, Informed About Medication Side-Effects (Note: CAMHD does not routinely provide medication management services, however this item affords data about how CAMHD clients perceive the information they receive from other providers), and Patient Rights Information, CAMHD scored above the national average. For Self-Care Information, CAMHD was comparable to the national average. CAMHD scored below the national 25-percentile for the following measures: Clinician Communications, Access to Treatment and Information, Rating of Counseling and Treatment, Seen Within 15 Minutes, and Able to Refuse Treatment. For Getting Treatment Quickly, CAMHD scored below the national average but above the 25-percentile.

Measure	National Average		CAMHD
	Mean	Percentile 25-75	
Getting Treatment Quickly	62%	59%-64%	60%
Clinician Communication	91%	90%-93%	84%
Access to Treatment/Information	73%	69%-77%	53%
Informed about Treatment Options	43%	41%-44%	59%
Rating of Counseling/Treatment	72%	70%-75%	61%
Seen Within 15 Minutes	84%	82%-87%	70%
Info on Medication Side Effects	81%	79%-84%	89%
Self-Care Information	78%	76%-80%	78%
Patient Rights Information	87%	84%-91%	90%
Able to Refuse Treatment	89%	88%-90%	85%

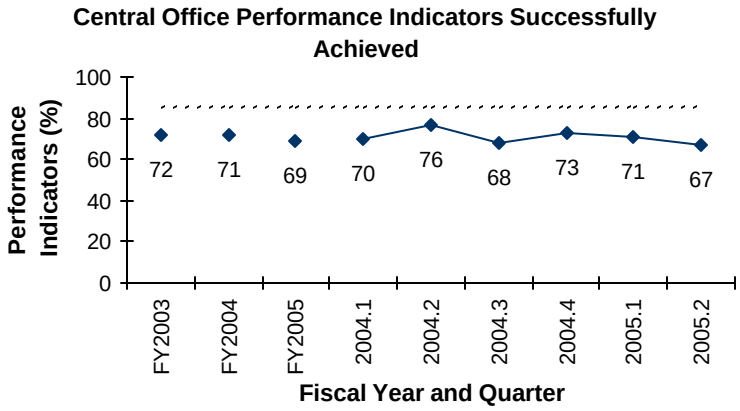
The comparison of CAMHD to national data has just been received and will be discussed at the next CAMHD Performance Improvement Steering Committee to determine areas of improvement in CAMHD service delivery.

There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section as accountability and planning tools. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 38 measures currently tracked by EEMT. In the second quarter, 67% of measures were successfully met, which falls short of meeting the performance goal for this quality indicator, and is below last quarter's performance. The measures that fell below their goals tended to revolve around timeliness issues. As discussed in last quarter's report, these results have largely been impacted by staff vacancies.



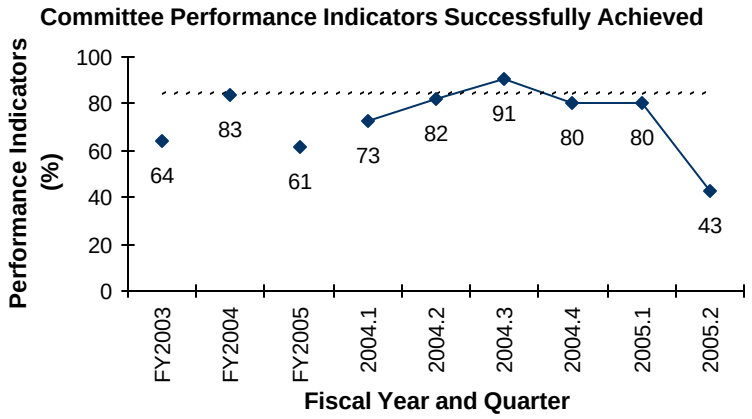
Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Credentialing, Safety and Risk Management, Grievance and Appeals, Utilization Management, Evidence-based Services, Compliance, Information Systems Design, and Training. A total of 22 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter 43% of performance measures were met through the work of the CAMHD Committees, which does not meet the goal for this quality indicator. This is a marked decline over last quarter's performance of 80% of measures met. A variety of committee performance indicators did not meet the goal including the committees for policy and procedures (percentage of milestones met), grievance and appeals (percentage of appeals decided upon in the meeting they are presented), credentialing (timely recredentialing measures), evidence-based services (article coding and updates to practice recommendations, which was impacted by the flooding of the Graduate Library at the University of Hawaii), and training (percentage of goals met). Improvement strategies have been developed for each measure not meeting goals.



Summary

The majority of performance goals were met or exceeded in the second quarter of fiscal year 2005 (October-December 2004). The asterisked measures are those linked to historical Federal Court benchmarks. Of these "sustainability measures," indicators met the performance goal in the reporting quarter except for the following measures:

- Two personnel vacancy measures: filled Care Coordinator positions, which was 5% below targeted performance, and Central Administration positions filled, which was 6% below target. Each of these measures improved by 1% over last quarter's performance as several vacancies were filled.
- Complexes maintaining acceptable scoring on Internal Reviews as one complex scored below 85%.

New in this section is the discrete reporting of Family Guidance Center performance. The FGCs had previously been grouped together, which did not allow for reporting on how each FGC performed in the quarter. In the quarter, the FGCs had to meet at least 12 of 14 measures in order to meet their performance goal (with the exception of Kauai and FCLB who had 13 and 2 performance indicators respectively).

The following were measures that met or exceeded goals:

- Care Coordinator caseloads within the range of 1:15-20 youth
- Timely access to the service array:
  - Youth receiving services within 30 days of request*
  - Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:*
  - Youth with no documented complaint received
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance
- Youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Performance Indicators met by the Central Oahu Family Guidance Center
- Performance Indicators met by the Honolulu Family Guidance Center
- Performance Indicators met by the Maui Family Guidance Center
- Improvements in child status as demonstrated by CAFAS or ASEBA*

The following measures demonstrated a stable or improving trend, but did not achieve the targeted goal:

- Contracted providers paid within 30 days
- Youth receiving treatment while living in their homes
- Child Status as measured by Internal Review Results
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review*
- Central Office Performance indicators

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies developed by the appropriate monitoring bodies.

- Filled Care Coordinator positions*
- Filled Central Administration positions*
- Maintaining services and infrastructure within the quarterly budget allocation
- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Leeward Family Guidance Center
- Performance Indicators met by the Hawaii Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center
- Performance Indicators met by the Family Court Liaison Branch
- State Committees' performance indicators

Satisfaction with CAMHD Services has converted to an annual measure, and there are no new data for the following measures:

- Overall satisfaction with counseling or treatment
- Overall satisfaction with company handling benefits

CAMHD continued to experience stable performance in most of the measures associated with sustaining Hawaii's system of care for children and youth with special needs. The three "Sustainability" measures that did not meet desired performance were Complex performance on Internal Reviews (one complex did not meet the performance goal), and two measures for filled positions (Care Coordinator and Central Administration.).
As discussed in last quarter's report, vacancies impact the service system across performance areas. The length of time to fill positions, as well as challenges in finding qualified staff are impacting several Family Guidance Centers, the Clinical Services Office, and the Management Information Systems section. For example, the Waimea FGC office has not had sufficient MHCC staffing for just under a year. This has led to high caseloads and reassignment of cases to staff outside of the Waimea area. Although recruitment has been ongoing, there have been challenges in identifying MHCCs to reside in this rural community. CAMHD is currently exploring downgrading the positions to assist with this recruitment effort. The Clinical Services Office has experienced challenges in recruiting for the Transition Specialist and two mental health specialists working with federally funded grant projects. The delay in these recruitment efforts has led to slow implementation of required training and support in designated areas. The Management Information Systems section has experienced vacancies in two critical data system developers for over a year, which has greatly hampered the ability to make needed improvements to the system. Although the system is currently functional, there are improvements needed in order to continue supporting practice and operational functions. The fiscal office has experienced vacancies in two accountant positions for an extended period of time; however, these positions are expected to be filled within the next several weeks. The Personnel Management Specialist position that manages CAMHD personnel office has undergone repeated turnovers. There is currently an emergency hire employee filling that position. The Performance Management Office has recently filled several positions, which had been vacant for a lengthy period. As such, the timeliness and quality measures are expected to rebound in that section.

While these factors tend to stretch the capacity of staff to provide services and manage infrastructure, the ability to provide services that are impacting youth and families positively continues to be realized.